

## **MONTANA BOARD OF MEDICAL EXAMINERS**

**PO Box 200513**

**(301 South Park Avenue 4<sup>th</sup> Floor – Delivery Only)**

**Helena MT 59620-0513**

**PHONE: 406-841-2380 or 406-841-2328      FAX: 406-841-2305**

**E-MAIL: [dlibsmed@mt.gov](mailto:dlibsmed@mt.gov)      WEBSITE: [www.emt.mt.gov](http://www.emt.mt.gov)**

### **ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.**

(Please allow 10 days for processing from the date the Board has a complete application)

#### **LICENSING REQUIREMENTS FOR EMERGENCY MEDICAL TECHNICIANS**

- ♦ NREMT Registration for appropriate level equal to or greater than level applying for
- ♦ Possess a high school diploma or its equivalent (e.g., G.E.D.)
- ♦ 18 years old or older

#### **FEES:**

- ♦ **\$20.00 – EMT First Responders**
- ♦ **\$30.00 – EMT Basic**
- ♦ **\$40.00 – EMT Intermediate**
- ♦ **\$60.00 – EMT Paramedic**

\*Make check or money order payable to the Montana Board of Medical Examiners\*

**DOCUMENTS:** The following documentation must be submitted to the Board office in order to complete your license application.

- ♦ **Proof of High School diploma or its equivalent, or college transcripts**
- ♦ **Birth Certificate or other verifiable evidence of the applicant's date of birth, ie. driver's license**
- ♦ **Current NREMT registration card equal to or greater than the level applying for**
- ♦ **RESULTS of a current self-query on the National Practitioners Databank (Letter Unopened)**

#### **ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:**

- ♦ **National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling NPDB at 800-767-6732 or visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) on the Internet. This form must be mailed directly to NPDB at the address indicated in the instructions on their form. The results will come to you; upon receipt please forward them to the Board office.

#### **APPLICATION PROCEDURES:**

- ♦ A verification of licensure or letter of good standing must be sent directly from each state board in which the applicant is currently or has ever been licensed to practice. Please make copies of the attached verification request form as needed. Some states charge a fee for verification. Contact each board prior to sending the request.

#### **PROCESSING PROCEDURES:**

- ♦ An application file must be complete before consideration of licensure. The applicant will be notified in writing of any items missing from the application file.
- ♦ An application takes 10 days to process from the time it is complete.
- ♦ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. A non-routine application may take up to 120 days to process.

**For information with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 841-2380 or (406) 841-2328 or e-mail us at [dlibsmed@mt.gov](mailto:dlibsmed@mt.gov)**

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**Application for Licensure as an Emergency Medical Technician**

☐ **First Responder**      ☐ **Basic**      ☐ **Intermediate**      ☐ **Paramedic**

**PLEASE TYPE OR PRINT IN INK.**

(Please allow 10 days for processing from the date that the Board has a complete routine application)

1. FULL NAME: \_\_\_\_\_  
Last First Middle

2. OTHER NAME(S) KNOWN BY \_\_\_\_\_

3. BUSINESS NAME \_\_\_\_\_

4. BUSINESS ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

5. HOME ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS      ☐ Business ☐ Home E-MAIL ADDRESS \_\_\_\_\_

6. TELEPHONE ( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
Business Home Fax

7. SOCIAL SECURITY NUMBER \_\_\_\_\_ FOREIGN ID NUMBER \_\_\_\_\_

8. DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_  
City/State ☐ MALE ☐ FEMALE

9. LICENSE NAME \_\_\_\_\_  
(State your name as it should appear on the license if granted.)

10. Have you ever previously applied for a license to practice in Montana? ☐ Yes ☐ No  
If yes, give date and results.

Type of License	Dates	Results of Application	License #

11. Have you ever been denied licensure or the opportunity to take a professional licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No
12. Have you ever withdrawn an application for an EMT license? If yes, please give the state and reason for withdrawal. ☐ Yes ☐ No

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.

13. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No
14. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No
15. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No
16. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No
17. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No
18. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No
19. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No
20. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No
21. Do you have any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No
22. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

23. List all certification/licenses that you hold or **ever** held, including EMT. Verifications for each license must be sent directly to Montana from each state certification/licensing board.

State	License# & Type	Issue Date	Expiration Date	License Method	Requested State Verification
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Exam <input type="checkbox"/> Endorse <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

### AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competency to practice by anyone who might possess such information to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instructions to applicants for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.

\_\_\_\_\_  
Legal Signature of Applicant

\_\_\_\_\_  
Dated

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Notary Public

**SEAL**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
For the State of

My commission expires \_\_\_\_\_, \_\_\_\_\_.

**VERIFICATION OF LICENSURE**

THIS IS NOT AN ENDORSEMENT CERTIFICATION

**PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS AN EMERGENCY MEDICAL TECHNICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.**

STATE BOARD:

I am applying for a license to practice as an EMT in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

\_\_\_\_\_  
(Signature) Name: \_\_\_\_\_  
(Please print)

Address: \_\_\_\_\_

My License Number is: \_\_\_\_\_

**DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS**

State of: \_\_\_\_\_

Full Name of Licensee: \_\_\_\_\_

License No. \_\_\_\_\_ Issue Date: \_\_\_\_\_

License is current? \_\_\_\_\_ If NO, explain \_\_\_\_\_

Has license been suspended, revoked, placed on probation or otherwise disciplined? \_\_\_\_\_

If YES, explain and attach documentation \_\_\_\_\_

Has licensee ever been requested to appear before your Board? \_\_\_\_\_

If YES, explain \_\_\_\_\_

Derogatory information, if any \_\_\_\_\_

Comments, if any \_\_\_\_\_

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

**BOARD SEAL**

State Board: \_\_\_\_\_ Date: \_\_\_\_\_